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1990 TEXAS BEHAVIORAL RISK FACTOR SURVEILLANCE

FINAL OVERVIEW

1990

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Dear Colleague:

This is the fourth annual report from our statewide Behavioral Risk Factor Surveillance System which was initiated in 1987. Data from this reporting system can be used to assess unhealthy lifestyle behaviors to help target health promotion efforts where they are most needed. Chronic diseases and injuries killed 23,515 Texans in 1990. There is still much that needs to be done to reduce the prevalence of the risk factors that contributed to these numbers.

Risk factor surveillance data are now collected in 46 states so that we are able to compare our results nationally. These data can also be used in measuring progress toward several Year 2000 Objectives.

Guided by data collected through surveillance activities such as this, we can all work together toward reducing premature death and disability by promoting healthy lifestyles for all Texans.

Sincerely,

David R. Smith, M.D.
Commissioner of Health

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EXECUTIVE SUMMARY

Introduction

- This behavioral risk factor prevalence report was prepared by the Texas Department of Health based on randomly selected telephone calls made to adult Texans in 1990. The specific behavioral risk factors for which data were collected are:

  * seat belt use
  * hypertension
  * diabetes
  * physical activity
  * weight
  * cholesterol and preventive health practices
  * cigarette smoking
  * alcohol use
  * AIDS
  * smoke detector use

The Department received funding and technical assistance from the Centers for Disease Control in support of this data collection effort. The telephone survey population was comprised of 1497 Texans 18 years of age or older. The data collected were self-reported, via telephone interviews, which may lead to an under-reporting of selected risks.

Information on the prevalence of certain risk factors in this report may be compared to that provided in the 1982, 1984, 1987, 1988 and 1989 Behavioral Risk Factor Survey reports to assess trends.

Seat Belt Use

National studies suggest that the use of seat belts can reduce motor vehicle deaths and injuries by 60 percent per year.[1] The vast majority of Texans and Americans recognize the benefits of seat belts, but 7 percent of adult Texans did not regularly utilize seat belts in 1990. Ten times more people reported buckling up since the Texas seat belt law passed in 1985.

Hypertension

Hypertension continues to afflict thousands in our state. Sixteen percent of Texans surveyed had been told they had high blood pressure more than once, and were taking medication.

Diabetes

Seventy-eight individuals or 5 percent from the sample reported diabetes. The number of diabetics reporting may be under-represented since there are approximately as many undiagnosed as those diagnosed.

Weight

The survey showed 26 percent of men and 19 percent of women were overweight (based on body mass index).

Cholesterol

Fifty-nine percent of adult Texans reported having their cholesterol checked, and of those who had it checked, 16 percent are under their doctor's advice to reduce their cholesterol or blood fat level.

[1] Auto Safety Belt Fact Book, US DOT, NHTSA

Physical Activity

Of the 53 percent of Texans who had a sedentary lifestyle, 29 percent of those reported no physical activity or exercise during the past month. More women than men reported a sedentary lifestyle. Only 9% of those interviewed met the 1990 objective for exercise.

Cigarette Smoking

Cigarette smoking is a priority health problem for the state although the smoking prevalence of 23 percent was less than the national average. The percent of males and females who smoke was 24 and 22 percent respectively.

Alcohol Use

Alcohol consumption in Texas was above the national average. Six percent of Texas adults drank an average of 60 drinks monthly. Driving after drinking was 5 percent, and binge drinking was reported to be 19 percent.

I. Introduction

The Texas Behavioral Risk Factor Surveillance System(BRFSS) is a federally funded project of the Texas Department of Health, Public Health Promotion Division, Risk Reduction Section. This project is designed to collect data on lifestyle risk factors which contribute to the major causes of death, chronic diseases and injuries.

This report describes a telephone survey conducted on a monthly basis in which 1497 randomly selected adult Texas residents were interviewed during January through December of 1990. Respondents were asked for information on selected lifestyle behaviors. The risk factors addressed in this surveillance include participation in cancer screening, cigarette smoking, high blood pressure, alcohol consumption, lack of exercise, obesity, and seat belt use. Information on knowledge and attitudes about AIDS was also collected. Implementation of health education programs designed to decrease these risks may reduce premature death and disability of Texas residents.

HEALTH OVERVIEW

Chronic diseases are the major contributor to mortality today (see Table 1). Risk factors which contribute to chronic diseases involve personal health choices and behaviors that are amenable to preventive measures and education. According to the 1979 Surgeon General's report Healthy People, as many as half of all U.S. deaths may be due to unhealthy behavior or lifestyle.[1] The report also states that by controlling five critical variables - diet, smoking, lack of exercise, alcohol abuse and use of anti-hypertensive medicine - seven of the ten leading causes of death in the U.S. could be substantially reduced.[1] Because lifestyle plays a predominant role in disease prevention, it is important that health officials measure the secular trends of disease causing or health enhancing behaviors. An appendix has been added in this report to highlight the applicable Year 2000 Texas Health Objectives to aid in determining achievement of these goals.[2]

1. Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention, U.S. Department of Health, Education, and Welfare, Public Health Service, 1979, p. 9.

2. Healthy Texans 2000 Partnership, 5/91 TDH Stock #4-156

Table 1

LEADING CAUSES OF DEATH IN TEXAS, 1990
RATES PER 100,000 ESTIMATED POPULATION

CAUSES OF DEATH	TOTAL DEATHS	RATE	PERCENT OF DEATHS
ALL CAUSES	125,019	736.8	100.0
1. Diseases of the Heart	39,443	232.2	31.5
2. Malignant Neoplasms	28,483	167.7	22.8
3. Cerebrovascular Diseases	8,388	49.4	6.7
4. Accidents and Adverse Effects	6,255	36.6	5.0
5. Chronic Obstructive, Pulmonary Disease and Allied Conditions	4,857	28.6	3.9
6. Pneumonia & Influenza	4,267	25.1	3.4
7. Diabetes Mellitus	3,458	20.4	2.8
8. Homicide	2,391	14.1	1.9
9. Suicide	2,156	12.7	1.7
10. Human Immunodeficiency Virus Infection	1,836	10.8	1.5
All Other Causes	23,515	138.4	18.8

Source: Texas Vital Statistics, 1990 Annual Report

PURPOSE AND GOALS OF SURVEILLANCE SYSTEM

Health departments traditionally have recorded mortality and morbidity trends. There has, however, been an ongoing attempt to monitor those behaviors that contribute to premature death and illness since 1982.

A systematic surveillance of behavioral risk factors is needed to establish population baselines, formulate health promotion objectives and establish intervention priorities. Future risk prevalence surveys will also help determine the long-term effectiveness of various risk reduction activities.

To meet this need, the Centers for Disease Control (CDC) provided assistance in the development of a standarized, active surveillance system. The routine collection of behavioral risk prevalence data allows the State to assess the aggregate, long-term impact of health promotion and risk reduction interventions in the community.

Specific goals of this project have been identified by CDC. Stated goals of the Behavioral Risk Factor Surveillance System are to:

1. Develop, implement, and manage a monthly surveillance system designed to determine and monitor the prevalence of behavioral risk factors.

2. Promote and implement a national coordinated system which utilizes standardized methodology, uniform data items and tabular displays.

3. Generate routine information rapidly and promote a collaborative effort in interpreting and disseminating information.

4. Evaluate the effectiveness of the surveillance system as an indicator of major behavioral risk factors and assess its capability to provide useful data for state program planning and evaluation.

II. Methodology

Participating Agencies

This survey was a combined effort of the Texas Department of Health and the Centers for Disease Control (CDC). The Department supervised the survey and prepared this report. The University of Texas, Office of Survey Research, through an interagency contract provided the telephones, office space, interviewers and the computer assisted telephone interviewing (CATI) Berkeley system. CDC provided financial assistance, developed the questionnaire, designed the methodology, provided training and processed the data.

Method of Surveillance

A telephone survey was used for this study rather than other survey methods because of its low cost, ease of administration, ease of reaching respondents, and reliability. Telephone surveys are less representative of areas where a significant portion of the population does not have telephone service. According to the Texas Public Utility Commission, approximately 91 percent of households in Texas have telephones. According to the Federal Communication Commission, 93% of U.S. households have telephones.[1]

Instrument Development

The survey questionnaire (see Appendix A) was developed by the Centers for Disease Control. Standard demographic questions were included along with sections on seat belt usage, hypertension, diabetes, exercise, diet and weight control, cigarette smoking, alcohol consumption and preventive health practices. Introduction, wording of the questions and transitional phrasing between questions resulted from extensive field testing by CDC.

Sample Size and Accuracy of Estimates

Estimates reported in this study for risk factor prevalence for the total adult population of Texas are accurate to within 1 to 3.4 percent at the 95 percent confidence level. According to sampling theory, the sample size necessary to achieve this level of accuracy is approximately 400, providing that the characteristic being examined is fairly representative of the population.

It should be noted that the level of accuracy described above applies only to estimates of prevalence for the general adult Texas population which is represented by the total sample of 1,497. Estimates of prevalence by gender, age, income, marital status or education categories do not reflect this level of accuracy and should be interpreted conservatively. Such estimates are presented in this report because they may suggest trends and help identify possible high-risk subpopulations.

It is important to remember this survey is based on self-reported data. Consequently, people may tend to report a more favorable lifestyle than actually practiced. Accuracy of self-reported data also may vary according to risk factors, i.e., self-reported smoking status is thought to be more accurate than self-reported seat belt use. These limitations do not negate the survey's ability to identify high-risk groups and monitor long-term trends. Extensive field testing and recent advances in collecting, processing and analyzing self-reported information have improved the quality of such data.

Eligible Respondent Selection

Eligible respondents for the survey were individuals 18 years of age or older who resided a majority of the time at the household contacted. In households with more than one eligible respondent, a random selection was made to determine the actual respondent. Prescreening was done to eliminate business phones or non-working numbers. If for some other reason the selected respondent was not able to complete the questionnaire, another randomly selected number was used. No answers and busy signals were redialed a minimum of four times on five different days at different times before being replaced.

1. Southwestern Bell Telephone, "Tele-help", 11/89.

Data Collection Process

All 1,497 interviews were completed between January 1, 1990 and December 31, 1990 at the rate of approximately 125 per month. Data were collected using the computer assisted telephone interview (CATI) system under an interagency contract with the University of Texas Office of Survey Research. The sample selection process included prescreening for residential exchanges each month by Texas Department of Health staff.

Completion Rates

The goal for 1990 was 1,500 completed interviews; 1,497 usable interviews were completed (99.8 percent). However, in order to complete these interviews, 4408 telephone numbers were activated resulting in 2671 possibilities for an interview. Completion rates based on these 2671 possibilities are shown in Table 2.

For random digit dial surveys, a refusal rate of less than 10 percent and a completion rate of 75 percent based on all possibilities of an interview are desirable. The refusal rate for this survey was 24.2 percent [1]. The completion rate of 56 percent was below the 75 percent goal in part due to Texas' rural nature which results in many non-working numbers.

Table 2

Completion Rates Based on all Possibilities of an Interview

Disposition	Number	Percent
1. Completed interview	1497	56
2. Refusal	479	18.0
3. No answer	517	19.3
4. Selected respondent Unavailable	169	6.3
5. Line Busy	9	.003
Total	2671	99.6

Data Processing

Since the survey utilized the CATI system, interview data were entered directly onto a diskette. The diskette was then forwarded to CDC. Tables showing frequencies and percentages for all questions by demographic categories were provided to the Public Health Promotion Division, Risk Reduction Section, by the Centers for Disease Control's Office of Surveillance and Analysis at the Center for Chronic Disease Prevention and Health Promotion.

Weighting

Collecting data via a telephone survey often produces an over-representation of certain groups in the sample population. The sample population, therefore, may not be a true representation of the actual population. In order to correct this inherent problem, weighting factors are computed by CDC to compensate for sampling bias and provide more representative population-based estimates of risk factor prevalence. Adjustments are also made to approximate estimates of age, race and sex as well as the respondents probability of selection. CDC adjustments also attempt to correct for telephone non-coverage, non-response and refusals.

1. 479 refusals/1,497 completed + 479 refusals = 24.2 percent.

Limitations

Telephone surveys are a cost-effective method of rapidly obtaining population-based data. However, a number of limitations must be kept in mind when interpreting these data.

Certain groups are excluded from or under-represented in telephone surveys; specifically, persons who do not live in a household with a telephone, people who are difficult to contact because of the hours they are at home, and people who refuse to participate. Insofar as these groups have behaviors which are different from the general population, the survey sample will be biased.

The validity of survey results also depends on the accuracy of responses by participants. All self-reported data are affected by the willingness of participants to respond honestly, this is especially important when considering the validity of responses to questions which are socially sensitive or assess adherence to the law. The self-reported nature of these data must be kept in mind when interpreting results.

Validity is also affected by the ability of the respondent to accurately interpret the question and recall past behavior. To minimize these problems BRFS incorporates questions which have been successfully used in previous surveys.

The Texas BRFSS was designed to produce prevalence data accurate at + or - 1.8% of the true mean values at the 95% confidence level. This means that the overall prevalence (percentages) obtained from the survey are within 1.8% of the responses expected of the total Texas adult population.

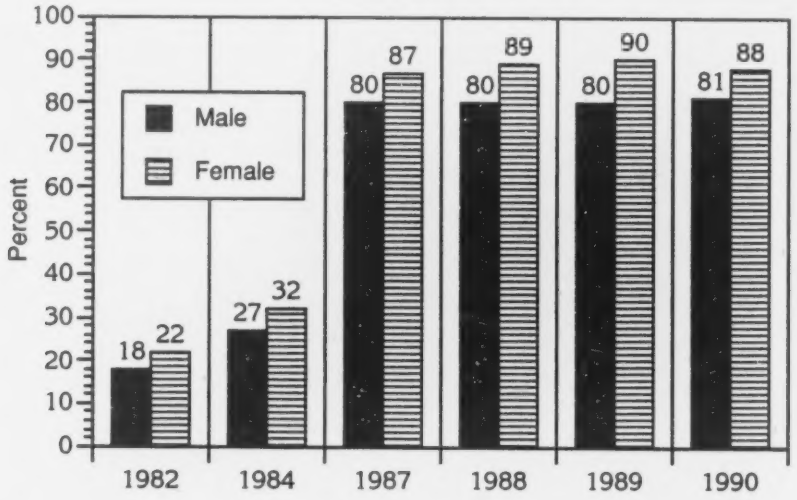
1990 BEHAVIORAL RISK FACTOR SURVEILLANCE RESULTS

Seat Belt Use

Eighty one percent of all men and eighty-eight percent of all women surveyed in 1990 indicated that they nearly always used seat belts (fig.1). The percentage of seat belt usage has remained steady since 1987. The influence of education on seat belt use remains apparent; in 1990, individuals with some college education or college graduates were more likely to nearly always use seat belts (87%) as compared to individuals with a high school education or less (83%). The youngest age group included in this survey (18-24) also proved to remain at high risk with only 80% reporting regular seat belt use. Finally, as reported income rises, so too does seat belt use. For example, while only 80% of the respondents earning less than $10,000 per year regularly used seat belts, from 85% to 89% of those earning between $20,000 to $50,000 regularly used seat belts, and over 92% of those earning $50,000 reported regularly using seat belts.

In summary, the increasing trend for seat belt use, which began in 1985 with mandatory seat belt use legislation, appears to have had an immediate impact as reflected by the 1987 BRFSS results. However, little improvement over the 1987 values has been detected since. Seat belt use remains associated with the demographic characteristics of those surveyed; better educated, more affluent, and older individuals are more likely to use seat belts on a regular basis.

Figure 1
Seat Belt Use



Hypertension

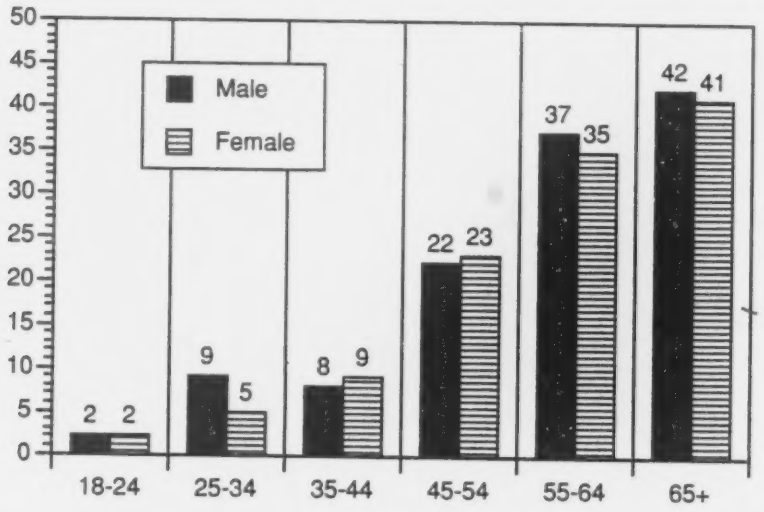
Approximately 58 million Americans have high blood pressure or are taking antihypertensive medication. It is a major risk factor for heart disease and stroke, the first and third leading causes of death in Texas. The condition is a complicating factor in disease of the kidneys, eyes and peripheral arteries.

Improved treatment and control of high blood pressure has resulted in decreased mortality from strokes over the past 15 years. The mortality rate from heart disease has also declined. Public education and advances in the treatment of high blood pressure will continue to play a role in reducing mortality from heart disease and stroke. The National High Blood Pressure Education Program recommends lifestyle modifications as the first approach to the treatment for high blood pressure. When medications are necessary, they have been demonstrated to clearly decrease cardiovascular mortality and morbidity and when used for persistent mild hypertension, protect against stroke, congestive heart failure and progression to more severe hypertension.

Current hypertensives are the known, diagnosed hypertensives in the population. It is defined by the National Heart, Lung and Blood Institute as respondents who report they have been told their blood pressure is high (greater than 140/90) more than once, or are on medication, or report their blood pressure is still high.

Sixteen percent of adult Texans reported they had been told more than once they had high blood pressure or were on antihypertensive medication. Males (15.9%) reported slightly less hypertension than females (16.4%). Those with income less than $10,000 were more at risk than the higher income groups. Of the working population, persons unemployed more than one year were more likely to report high blood pressure. Figure 2 shows the prevalence of hypertension by age and sex.

Figure 2
Current Hypertension by Age and Sex



Diabetes

In 1990, 830,000 Texans are estimated to have diabetes. It is one of the ten leading causes of death in Texas. Blindness, heart disease, renal disease, peripheral vascular disease, birth defects and premature mortality can result from uncontrolled diabetes. Many of these complications can be avoided or delayed with careful management, client education and appropriate medical intervention. Diabetes is costly in terms of human suffering and in the economic cost to the health care system. The economically disadvantaged and minority populations experience a higher incidence of this disease.

Between 90-95 percent of all persons who develop diabetes will have the adult onset, or Type II diabetes (non-insulin dependent form). Sixty-six of the 78 respondents reporting diabetes were over 35 years of age.

Five percent of the of respondents reported having a diagnosis of diabetes. This number may be under represented in the general population since there are approximately as many undiagnosed persons with diabetes as those who have the disease.

Physical Activity

Regular exercise plays an important role in the overall health of an individual. Studies have shown that vigorous physical activity on a regular basis reduces the risk of coronary heart disease and anxiety. In addition, evidence suggests that physical activity may have important beneficial effects on hypertension, non-insulin dependent diabetes, and osteoporosis. People who engage in regular physical activity report that they feel better in general and have more energy.

In the survey, respondents were divided into the following activity levels to assess risk:

1) Those who meet the 1990 Health Objectives for the Nation by exercising at 60 percent of individual cardiorespiratory capacity for 20 minutes or more, three or four times a week.

2) People who had regular activity 20 or more minutes three or four times a week but who exercised at less than 60 percent of an individual's cardiorespiratory capacity.

3) Irregular exercisers who performed a physical activity less than 20 minutes or less than three times a week.

4) Those who reported no physical activity.

Survey results, by activity level, are summarized in Figure 3. The Centers for Disease Control defines sedentary lifestyle as respondents who report either no physical activity or levels of physical activity less than three times per week or less than 20 minutes per occasion.

Figure 3
Physical Activity Level

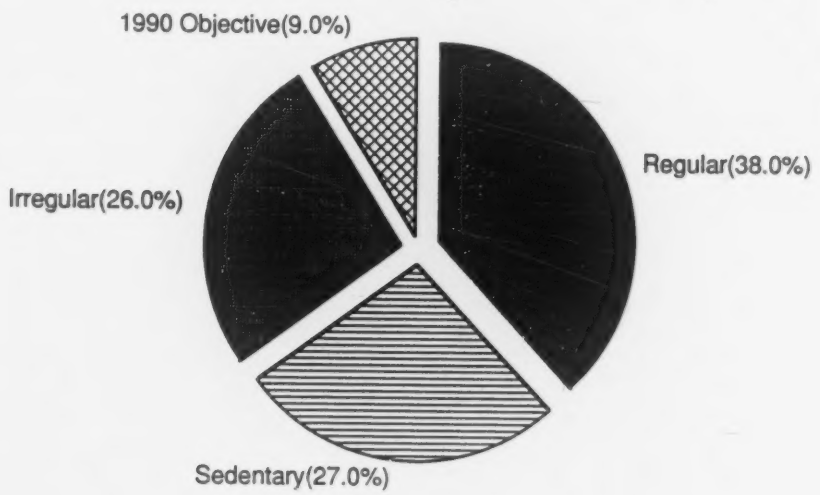
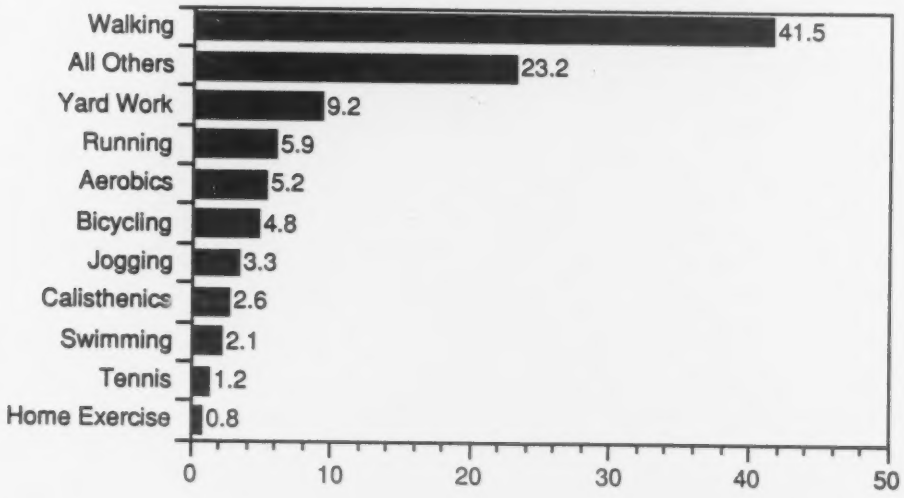


Figure 4 shows the relative frequency of primary physical activities.

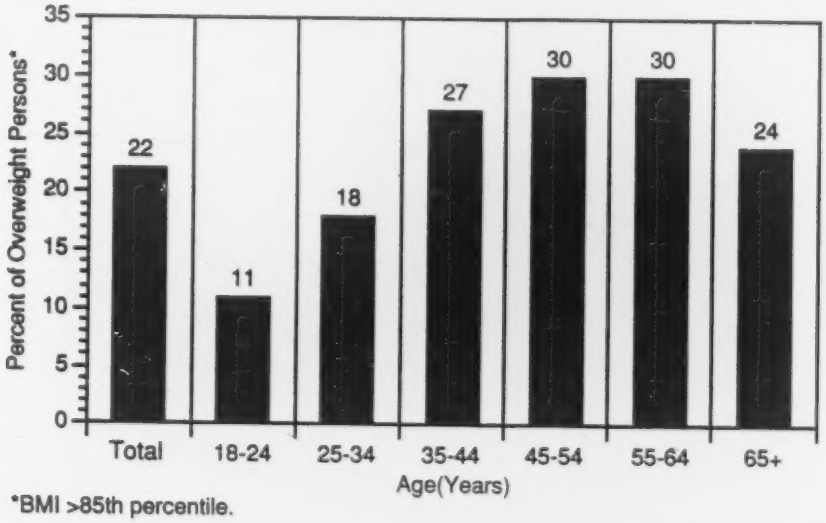
Figure 4
Frequency of Primary Physical Activity



Weight

People are considered overweight if their body mass index (BMI), a ratio of weight to height, exceeds the 85th percentile (>27.3 for women and >27.8 for men).[1] According to BMI, 22% of the adults in this survey were overweight. More men were overweight (26%) than women (19%), and the prevalence of overweight was highest among people ages 45-64 years (30%). (Figure 5)

Figure 5
Prevalence of Overweight by Age



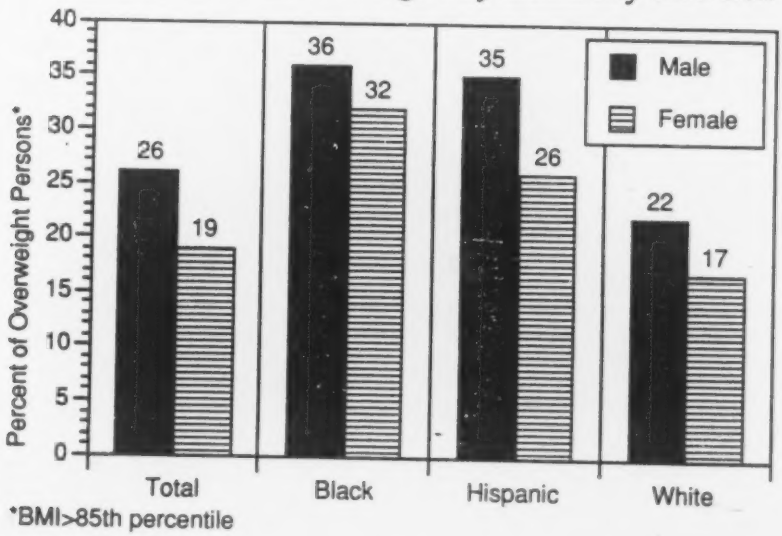
*BMI >85th percentile.

1. Najjar MF, Rowland M. Anthropometric reference data and prevalence of overweight—United States, 1976-80. Hyattsville, Maryland: US Department of Health and Human Services, Public Health Service, 1987. DHHS publication no. (PHS) 87-1688. (Vital and health statistics; series 11, no. 238).

As illustrated in Figure 6, black men and black women had the highest rates of overweight (36% and 32%, respectively) when compared with men and women of other ethnic backgrounds.

Figure 6

Prevalence of Overweight by Ethnicity and Sex



There is a well-established relationship between overweight and an increased risk for diabetes, heart disease, hypertension, stroke, some types of cancer, and gallbladder disease. Among the overweight persons in this survey, the prevalence of hypertension and diabetes were increased (Figures 7 and 8). Overweight persons were three times as likely to have diabetes, and more than twice as likely to have hypertension.

Figure 7

Prevalence of Hypertension by Weight Status

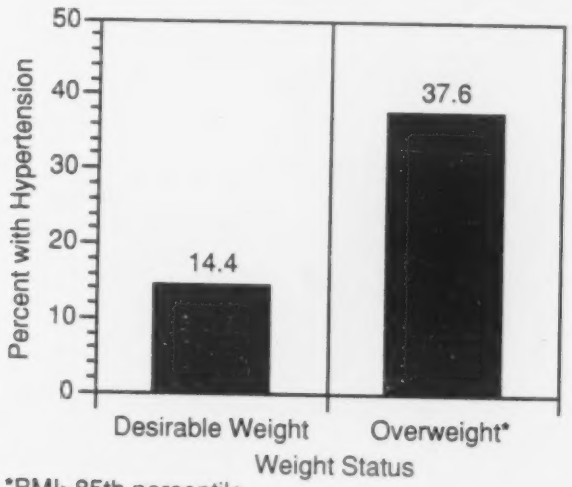
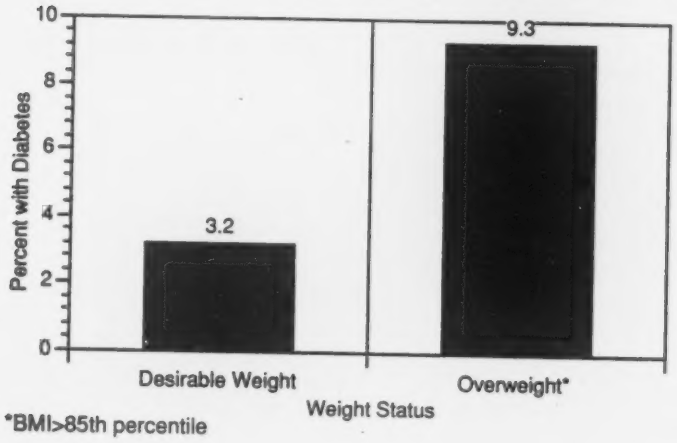


Figure 8

Prevalence of Diabetes by Weight Status



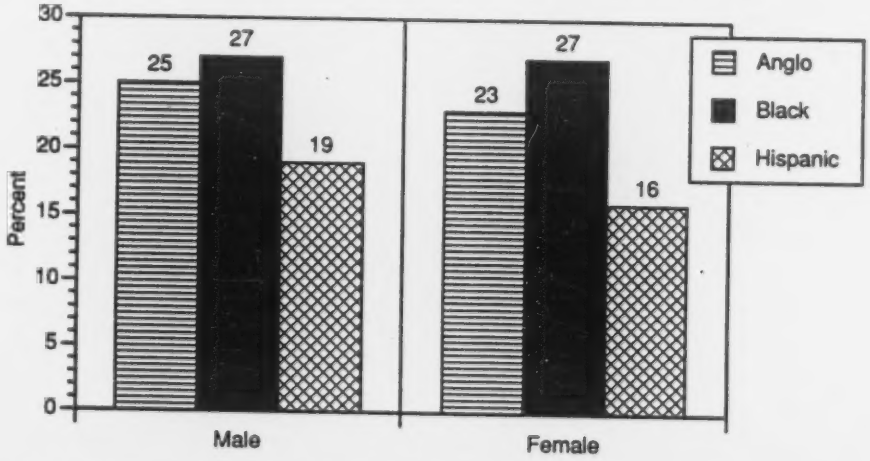
Tobacco Use

Tobacco use causes over 23,000 deaths in Texas each year. The 1989 Surgeon General's Report estimated that smoking is responsible for 30% of all cancer deaths, including 87% of lung cancer deaths.

Results of the 1990 survey show that 23% of Texans are current smokers, 24% are former smokers, and 52% have never smoked. Men continue to smoke more often than females (24% versus 22%), and are more likely to be former smokers. Women however, smoked more than men in the age groups 18-24 (19% versus 17%) and 55-64 (30% versus 21%). Four percent of males and 3% of females reportedly smoked more than 2 packs a day. Black males and females had the highest smoking prevalence and Hispanic males had females and the lowest smoking prevalence. Figure 9 shows the 1990 percentage of Texas smokers by sex and race/ethnicity.

Figure 9

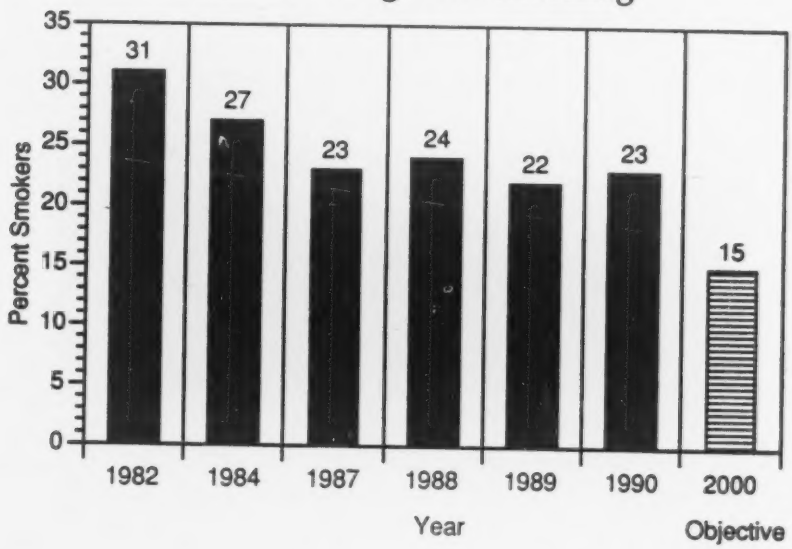
Current Smokers by Sex and Race/Ethnicity



Smoking prevalence in Texas has remained fairly stable since 1987. Continued efforts to increase education and smoking cessation programs must be initiated if we are to reach the year 2000 objective of reducing the percentage of Texas smokers to 15%. Figure 10 shows smoking trends in Texas 1982-1990.

Figure 10

Trends in Cigarette Smoking

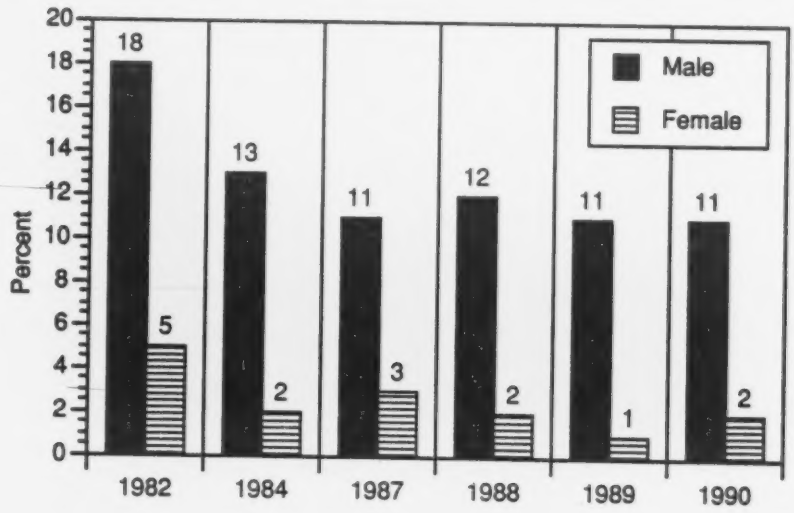


Alcohol Misuse

Chronic or heavier drinking is defined as alcohol consumption averaging two or more drinks a day (60 or more during the last month). The 1990 prevalence of heavier drinking by Texans was 6 percent, the same as in 1989. Also unchanged since 1989 was that 11 percent of men reported being heavier drinkers. The percentage of women who reported being heavier drinkers increased from 1 to 2 percent.

Figure 11

Chronic Alcohol Use



Acute or binge drinking is defined as having 5 or more drinks on at least one occasion one or more times during the previous month. The 1990 prevalence of acute drinking was remained the same as in 1989, 19 percent. Twenty nine percent of men and 9 percent of women reported being binge drinkers, an increase of 1 percent for men, and a decrease of 1 percent for women. (Fig 12)

In Texas in 1990, 1,402 people were killed in alcohol related traffic accidents, an increase of 7 percent over the 1989 figure of 1,306. Five percent of Texans reported having driven after having too much to drink, one or more times in the last month. Eight percent of men, the same as in 1989, reported drinking and driving. The percent of women who reported drinking and driving in 1990 decreased from 3 to 2 percent.

The year 2000 Objective related to alcohol abuse is to reduce to 30% the proportion of motor vehicle fatalities in which alcohol or drugs were contributing factors. In 1990, in Texas, 42% of all statewide fatal accidents involved DWI, driving while intoxicated. Texas has just 10 years in which to reduce alcohol/drug related fatal accidents by 12%.

Fig 13 and Table 3 show the prevalence of drinking by related demographics.

Figure 12
Alcohol Use by Sex

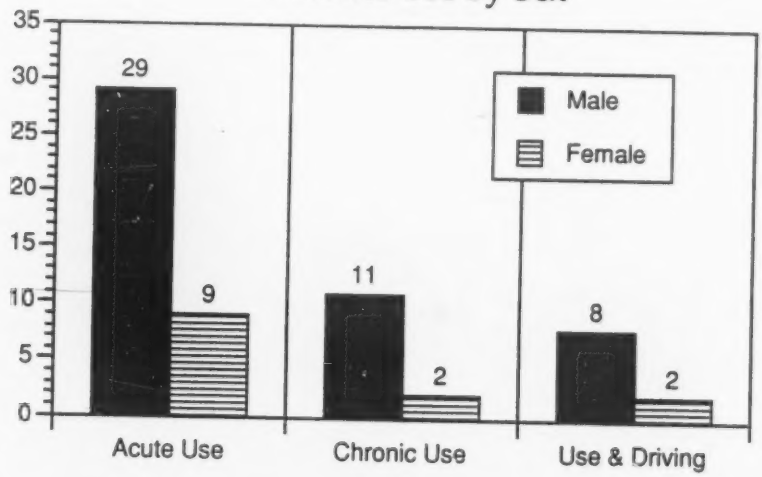


Figure 13
Alcohol Use by Age

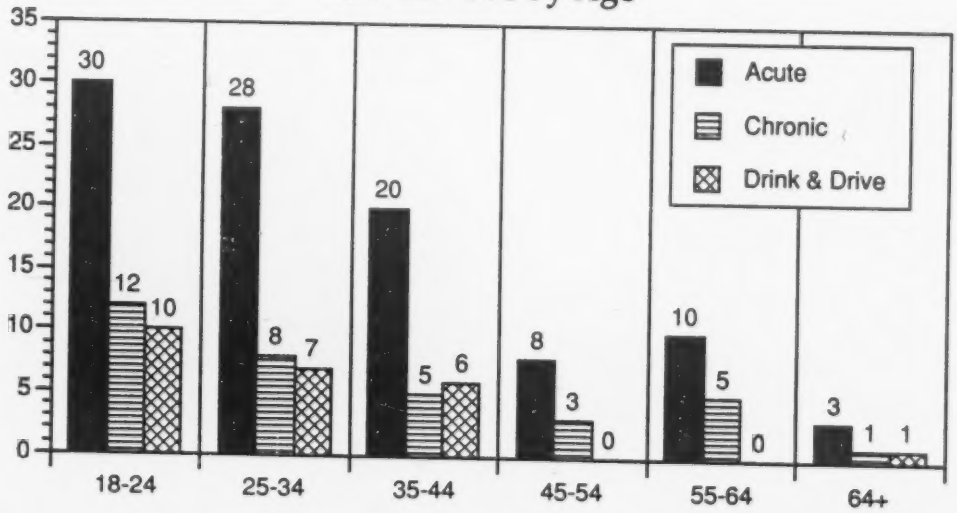


Table 3

Prevalence of Drinking Patterns by Selected Characteristics[1]

Characteristics	Chronic Drinking Percent	Binge Drinking Percent	Drinking & Driving Percent
AGE			
18-24	21	21	28
25-34	38	42	39
35-44	23	24	30
45-54	8	6	0
55-64	6	4	0
65+	4	3	3
	100%	100%	100%
RACE			
White	72	69	72
Black	8	8	9
Hispanic	20	22	18
Other	0	1	1
	100%	100%	100%
INCOME			
<$10,000	13	12	18
$10,000 - $24,999	31	33	31
>$25,000-	49	50	47
Refused	7	5	4
	100%	100%	100%
EDUCATION			
<12 YEARS	20	10	9
12	35	31	32
13-15	21	32	28
16+	24	26	31
Refused	0	1	0
	100%	100%	100%

[1] Of 71 respondents at risk

Texans reported twice the national average for chronic drinking and higher than the national average for drinking and binge drinking. This is a problem that the Texas Commission on Alcohol and Drug Abuse and others are diligently working to improve.

Mammography

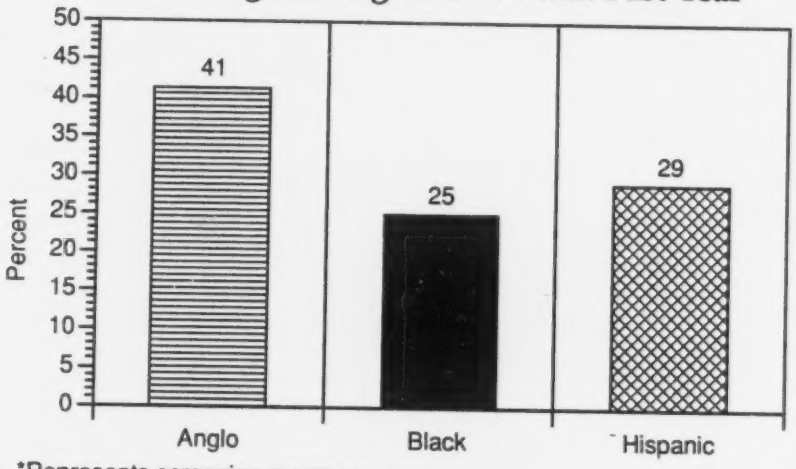
Among women in the U.S., breast cancer is the most common cancer representing twenty-eight percent of all cancers found in women. Breast cancer is the leading cause of death for women aged 35-54 years and an estimated one in nine women will develop breast cancer sometime during their lifetime. In Texas, in 1990, 2,246 women died of breast cancer and an estimated 7,700 women were diagnosed with breast cancer.

Breast self examination, clinical breast examination and breast x-rays or mammograms are effective techniques used to identify breast cancers. American Cancer Society and National Cancer Institute guidelines recommend a baseline mammogram for women between the ages of 35 and 39, a mammogram every two years for women age 40 to 49, and a yearly mammogram for women age 50 and over. If Texas women strictly followed these guidelines, an estimated 673 breast cancer deaths would have been prevented in 1990.

Results from the 1990 survey show that 56 percent of women age fifty and over received a routine clinical breast exam within the past year. However, only 38 percent of women age fifty and above had a screening mammogram within the past year. This is well below the year 2000 Objectives, which is to increase to fifty percent the number of women age 50 and older who receive a yearly mammogram. Women in the 40-49 age group faired better, as 50 percent received a screening mammogram within the requisite two years as recommended by national guidelines. Figure 14 shows that less than a third of both black and Hispanic females age 50 and over received a screening mammogram in 1990. Anglo women were the most likely to follow screening guidelines.

Figure 14

Percent of Women>=50 Years of Age Receiving Mamograms* Within Past Year



*Represents screening mammogram

Respondents age fifty and older cited "not needed/not necessary" (42 percent) as the leading reason for not having had a mammogram within the past year. Another 17 percent stated a mammogram was not recommended by a doctor. Only 8 percent cited cost as a reason for not having a mammogram within the past year. Breast cancer is a treatable disease, especially when diagnosed in the early stages. Mammographic screening can detect breast problems in the earliest stages when treatment is most effective. Increased educational efforts are needed to make women and health care providers more aware of the importance of mammograms.

Cholesterol

Survey respondents were considered at risk if they reported a blood cholesterol level equal to or greater than 200 mg/dl. The results include those reporting a borderline-high cholesterol (>=200-239 mg/dl) or high blood cholesterol (>=240 mg/dl), as defined by the National Heart, Lung, and Blood Institute (NHLBI). Twelve percent of the respondents reported cholesterol levels meeting the NHLBI criteria for being at risk.

Fifty-nine percent of Texans reported ever having their blood cholesterol checked. Females (61%) were more likely to have had their cholesterol checked than males (57%). Seventy-seven percent of the respondents reported having blood-cholesterol measurements within the past year.

Sixteen percent of the respondents were advised by their physician to reduce cholesterol. Of these, 81% were advised to adopt a low fat or low cholesterol diet, and 28% were prescribed medication. Twenty-six percent were referred to a dietitian for assistance in dietary modification.

Routine Checkups

Sixty-four percent of Texans reported visiting their doctor for routine checkups within the past year while 10 percent reported that it had been more than five years. More women (75%) than men (52%) have had a routine checkup in the past year.

Sixty-six percent of the respondents were seen by a family or general practitioner for their routine checkups.

Smoke Detector

Eighty-six percent of the respondants reporting having a smoke detector in their home and 49 percent had tested their detector within the past month to see if it worked.

Acquired Immunodeficiency Syndrome

By the end of 1990, 11,525 AIDS cases had been reported to the Texas Department of Health. Although there is no cure for the human immunodeficiency virus (HIV) that causes AIDS, progress has been made in slowing the course of the disease with medications and improved medical management. Despite advances, HIV infection became the 10th leading cause of death in Texas in 1990. However, the risks of HIV infection can be reduced by knowledge of how to avoid the disease.

Knowledge and attitudes often determine behavior. What people know and think about HIV and AIDS are important features of risk factor surveillance; they are also important in developing HIV prevention and education messages. Questions about AIDS knowledge and attitudes were therefore added to the survey in 1990 as indirect measures of risk behavior.

HIV/AIDS Knowledge

The questions used to measure knowledge are shown below. The correct responses, based on current scientific information and expectations of public awareness, are enclosed in parentheses.

Have you ever heard of the AIDS virus called HIV? (Yes)

To your knowledge, are there drugs available which can lengthen the life of a person infected with the AIDS virus? (Yes)

Do you think a person who is infected with the AIDS virus can look and feel well and healthy? (Yes)

Do you think you can get infected from giving blood? (No)

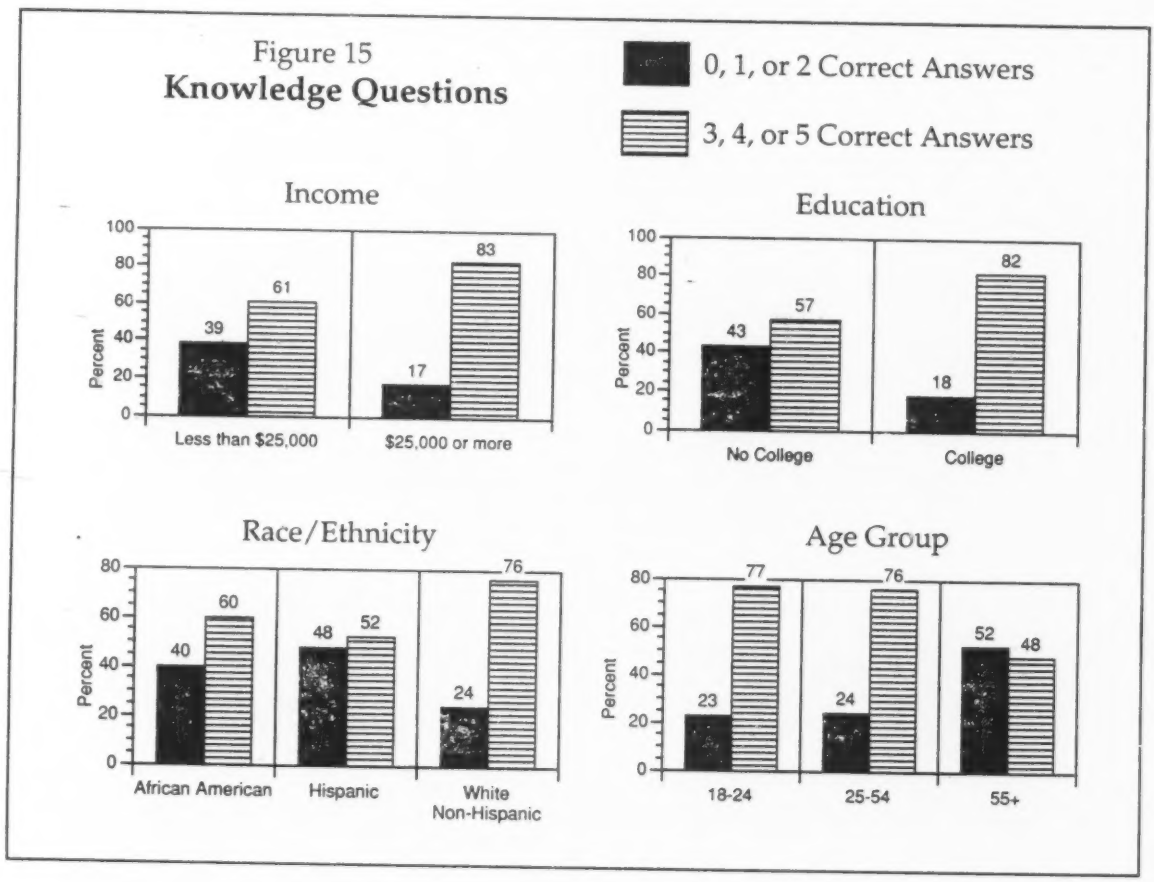
Do you think you can get infected from mosquitoes or other insects? (No)

Sixty-nine percent of the respondents gave correct answers to three or more of the five AIDS knowledge questions; the remaining 31% answered none, one, or two correctly. Knowledge about the disease was related to age, household income, education, and racial or ethnic group (See Figure 15.) These demographic factors are useful in identifying populations whose knowledge about AIDS needs to be increased.

However, the demographic factors related to AIDS/HIV knowledge are themselves often intertwined. For example, older people obtained most of their formal education at a time when AIDS was unknown, so their relative lack of knowledge about HIV compared to younger people may be due to unequal education opportunities rather than age itself. In the past, more African Americans and Hispanics than others have been denied equal education and employment opportunities. Data from this survey show that Non-Hispanic Whites still have higher income and education levels than African Americans or Hispanics, as well as more knowledge of AIDS. The ability to get an education often depends, in part, on income. Thus, what may appear to be a lack of knowledge due to race or ethnicity may, in fact, be a lack of knowledge due to educational inequalities. Race, ethnicity, age, income, and gender do not themselves determine knowledge; education does.

Men and women were equally knowledgeable about AIDS. Overall, 91% of those surveyed had heard of AIDS, 65% knew mosquitoes and other insects pose no threat, 64% knew HIV-infected people can look and feel healthy, 59% knew giving blood is not a risk, and 46% were aware of drugs which can lengthen the lives of people with HIV or AIDS.

Figure 15
Knowledge Questions



HIV/AIDS Attitudes

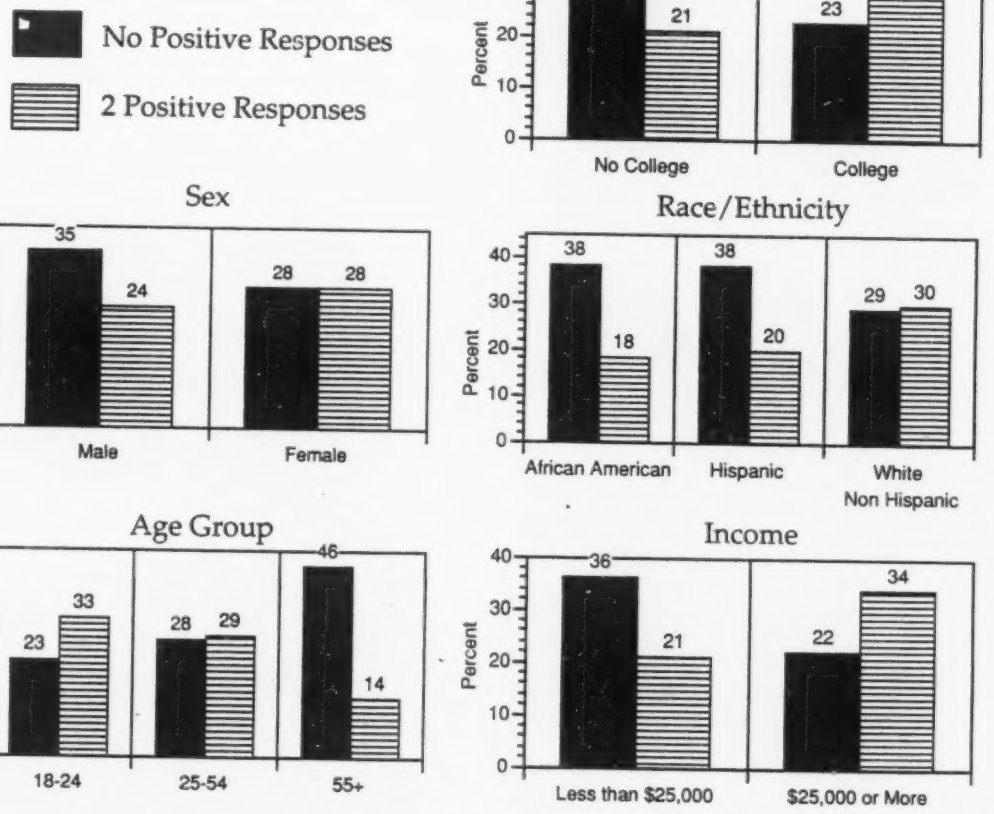
The questions used to measure attitudes towards contacts with HIV-infected people in situations involving no known risk of infection are shown below.

Would you eat in a restaurant where the cook is infected with the AIDS virus?

Would you be willing to work with a person who is infected with the AIDS virus?

Twenty-six percent responded "Yes" to both questions, showing an understanding that during the ten years of the AIDS epidemic, no evidence of transmission through routine social contacts or food preparation has ever been discovered. Nevertheless, 42% gave positive responses to only one of the 2 questions and 32% gave no positive responses. Attitudes were related to income, education, age, race or ethnicity, and gender. (See Figure 16) People with less education or income gave more negative or neutral responses than others; those with more education or income gave more positive responses. People age 55 and older gave negative or neutral responses more often than younger adults age 18 to 54. African Americans and Hispanics were more likely than White Non-Hispanics to say "No" or "Don't Know" to both questions. Overall, 68% said that they would be willing to work with a person who is infected with the AIDS virus, but 62% said they would not eat in a restaurant where the cook has AIDS.

Figure 16
Attitude Questions



HIV/AIDS Education

The questions used to measure parents' attitudes towards their children's education and HIV/AIDS are shown below.

Would you allow your child to be in the same classroom with a child who is infected with the AIDS virus?

What grade do you think your child should begins AIDS education in school?

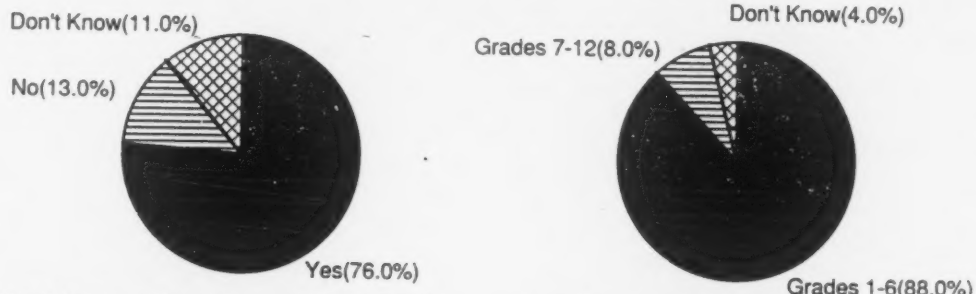
Each participant was asked if he or she had children in kindergarten through eighth grade; those who said "Yes" were then asked questions about AIDS and education. The parents were more likely to be Hispanic or African American than other survey respondents; they also tended to have higher incomes than others and to fall in the age group 25-54.

Seventy-six percent of the parents surveyed said they would allow their child to remain in a classroom with a fellow student who has HIV/AIDS. (See Figure 17.) White Non-Hispanic parents said "Yes" to this question more often than African American parents, who, in turn, said "Yes" more often than Hispanic mothers and fathers. The gender of parents made no difference in their responses, but higher incomes and education levels were associated with positive responses.

Eighty-eight percent of the parents with younger school children want their children to begin AIDS education in elementary school. (See Figure 17 .) Only 7% prefer that such education be delayed until junior high (grades 7-9) and only 1% want AIDS education to start as late as high school (grades 10-12). The preference for early AIDS education was very general: parents' age, income, race or ethnicity, and gender made no difference in their responses.

Parents' responses about AIDS and education demonstrated an understanding that their children cannot become infected with HIV through casual contacts in the classroom. Most believed that their children' education about the disease must begin at an early age, before they engage in high risk behavior. Both perceptions are in accord with current findings from public health research.

Figure 17
AIDS and Education
(Parents with Children in Grades K-8)


Don't Know(11.0%)
No(13.0%)
Yes(76.0%)
Would you allow your child to be in the same classroom with a child who is infected with the AIDS virus ?
Don't Know(4.0%)
Grades 7-12(8.0%)
Grades 1-6(88.0%)
At what grade do you think your child should begin AIDS education in school ?

Condom Opinions

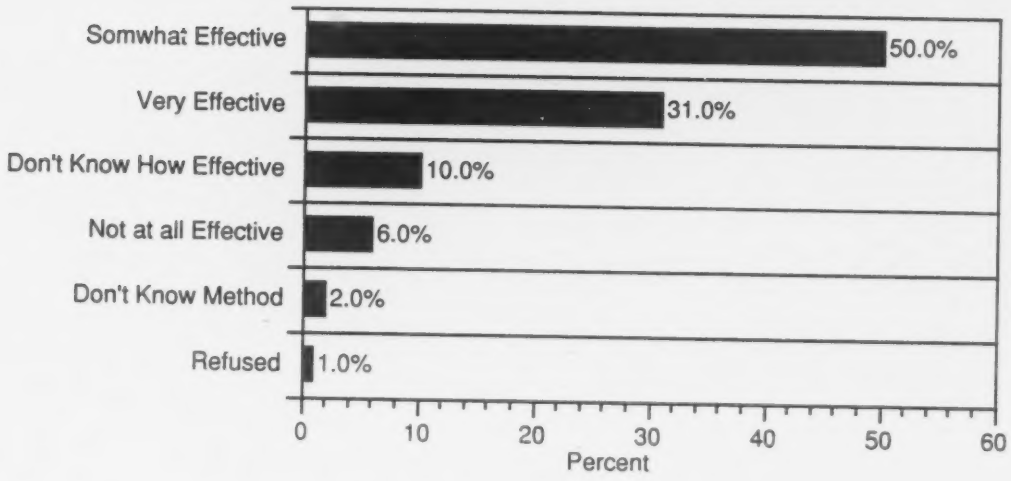
The question used to measure people's opinions on how well condoms work to prevent HIV infection is shown below.

How effective do you think using a condom is in preventing getting the AIDS virus through sexual activity?

Eighty-one percent of those polled thought that condoms are either very effective or somewhat effective in preventing exposure to HIV through sexual activity. (See Figure 18.) However, 50% said that condoms are "Somewhat Effective," while only 31% responded, "Very Effective." When used properly, latex condoms are potent tools in preventing AIDS. Only 6% of those surveyed believed that condoms are ineffective. Others did not know how well condoms protect against the AIDS virus (10%) or they were unfamiliar with this method of HIV prevention (2%). Very few of the Texas respondents refused to answer the question (1%). Men were more likely than women to view condom use as highly effective. African Americans answered "Very Effective" more often than Non-Hispanic Whites, who, in turn, gave this response more often than Hispanics. People with incomes below $25,000 were more likely than others to think that condom use is not at all effective in preventing exposure to the virus that cause AIDS. People with at least some college education and younger people believed condom use is very effective in preventing contact with HIV more often than their counterparts in the survey. The most common way HIV is spread is through sexual activity. Viewing condoms as effective in preventing HIV infection may be of prime importance in checking the mounting HIV epidemic.

Figure 18

How Effective Do You Think Using a Condom Is in Preventing Getting the AIDS Virus Through Sexual Activity?



CONCLUSION

Many of today's important health problems are influenced by health risk factors. Although some risk factors related to heredity cannot be changed, there are many lifestyle choices that can be made to decrease the risk of premature death and disability.

As evidenced by the risk factor data in this report, much still remains to be done to improve the health risk behaviors of Texans. The Department will continue to use the Behavioral Risk Factor Surveillance System to evaluate risk factor trends, prioritize health objectives and support health legislation. Any questions regarding behavioral risk factor surveillance can be directed to the Public Health Promotion Division, Risk Reduction Section, attention Juli Fellows or Roger Diamond, (512), 458-7405.

APPENDICES

APPENDIX A: 1990 Questionnaire

3

The interview will only take a short time, and all the information obtained in this study will be confidential. First, I'd like to begin by asking you about using seat belts.

SECTION A: SEAT BELTS

1. How often do you use seat belts when you drive or ride in a car?

Would you say: *PLEASE READ* (31)

a. Always 1
b. Nearly Always 2
c. Sometimes 3
d. Seldom 4
e. Never 5

DO NOT READ THESE RESPONSES

Don't know/Not sure 7
Never drive or ride in a car 8
Refused 9

SECTION B: HYPERTENSION

These next questions are about hypertension or high blood pressure:

2. Have you ever been told by a doctor, nurse, or other health professional that you have high blood pressure? (32)

a. No *GO TO SECTION C (a.k)* 1

PROBE FOR DOCTOR, NURSE OR OTHER HEALTH PROFESSIONAL

b. Yes, by a doctor 2
c. Yes, by a nurse 3
d. Yes, by other health professional 4

Don't know/Not sure *GO TO SECTION C (a.k)* 7
Refused *GO TO SECTION C (a.k)* 9

4

3. Have you been told on more than one occasion that your blood pressure was high, or have you been told this only once? (33)

a. More than once 1
b. Only once 2

Don't know/Not sure 7
Refused 9

4. Is any medicine currently prescribed for your high blood pressure? (34)

a. Yes 1
b. No *GO TO SECTION C (a.k)* 2

Don't know/Not sure *GO TO SECTION C (a.k)* 7
Refused *GO TO SECTION C (a.k)* 9

5. Are you currently taking medicine for your high blood pressure? (35)

PROBE FOR "All or most of the time" OR "Only occasionally" IF NECESSARY.

a. Yes, all or most of the time 1
b. Yes, only occasionally 2
c. No 3

IF ANSWER IS "Yes", USE "Yes, all or most of the time."

Don't know/Not sure 7
Refused 9

5

SECTION C: EXERCISE

The next few questions are about exercise, recreation, or physical activities other than your regular job duties.

6. During the past month, did you participate in any physical activities or exercises such as running, calisthenics, golf, gardening, or walking for exercise? (36)

a. Yes 1
b. No *GO TO SECTION D (a.k)* 2

Don't know/Not sure *GO TO SECTION D (a.k)* 7
Refused *GO TO SECTION D (a.k)* 9

7. What type of physical activity or exercise did you spend the most time doing during the past month? (37-38)

a. Activity *(specify)*: _____ — —
See Coding List A

Refused *GO TO Q 11 (a.k)* 9 9

ASK QUESTION 8 ONLY IF ANSWER TO QUESTION 7 IS RUNNING, JOGGING, WALKING, OR SWIMMING. ALL OTHERS, GO TO QUESTION 9 (a.k).

8. How far did you usually walk/run/jog/swim? (39-41)

SEE CODING LIST B IF RESPONSE IS NOT IN MILES AND TENTHS

a. Miles and tenths . . . . . — — . —

Don't know/Not sure 7 7 7
Refused 9 9 9

6

9. How many times per week or per month did you take part in this activity during the past month? (42-44)

a. Times per week . . . . . 1 — —
b. Times per month . . . . . 2 — —

Don't know/Not sure 7 7 7
Refused 9 9 9

10. And when you took part in this activity, for how many minutes or hours did you usually keep at it? (45-47)

a. Hours & Minutes . . . . . — : —

Don't know/Not sure 7 7 7
Refused 9 9 9

11. Was there another physical activity or exercise that you participated in during the last month? (48)

a. Yes 1
b. No *GO TO SECTION D (a.k)* 2

Don't know/Not sure *GO TO SECTION D (a.k)* 7
Refused *GO TO SECTION D (a.k)* 9

12. What other type of physical activity gave you the next most exercise during the past month? (49-50)

a. Activity *(specify)*: _____ — —
See Coding List A

Refused *GO TO SECTION D (a.k)* 9 9

ASK QUESTION 13 ONLY IF ANSWER TO QUESTION 12 IS RUNNING, JOGGING, WALKING, OR SWIMMING. ALL OTHERS GO TO QUESTION 14.

13. How far did you usually walk/run/jog/swim? (51-53)

SEE CODING LIST B IF RESPONSE IS NOT IN MILES AND TENTHS

a. Miles and tenths . . . . . — — .—

Don't know/Not sure 7 7 7

Refused 9 9 9

14. How many times per week or per month did you take part in this activity? (54-56)

a. Times per week . . . . . 1 — —

b. Times per month . . . . . 2 — —

Don't know/Not sure 7 7 7

Refused 9 9 9

15. And when you took part in this activity, for how many minutes, or hours did you usually keep at it? (57-59)

a. Hours & minutes . . . . . — : — —

Don't know/Not sure 7 7 7

Refused 9 9 9

SECTION D: TOBACCO USE

Now I'd like to ask you a few questions about cigarette smoking.

16. Have you smoked at least 100 cigarettes in your entire life? (60)

100 CIGARETTES = 5 PACKS

a. Yes 1

b. No GO TO SECTION E (a.18) 2

Don't know/Not sure GO TO SECTION E (a.18) 7

Refused GO TO SECTION E (a.18) 9

17. Do you smoke cigarettes now? (61)

a. Yes 1

b. No GO TO Q.22 (a.8) 2

Refused GO TO SECTION E (a.18) 9

18. On the average, about how many cigarettes a day do you now smoke? (62-63)

1 PACK = 20 CIGARETTES

a. Number of cigarettes . . . . . — —

b. Don't smoke regularly 8 8

Refused 9 9

19. Have you ever made a serious attempt to stop smoking cigarettes? (64)

a. Yes 1

b. No GO TO SECTION E (a.18) 2

Refused GO TO SECTION E (a.18) 9

20. When was the start of your most recent quit attempt? (65)

a. Past week 1

b. Past 2 weeks 2

c. Past month 3

d. Past 6 months 4

e. Past year 5

f. More than 1 year ago 6

Don't know/Not sure 7

Refused 9

21. How long did you actually stay off cigarettes that time? (66)

a. Less than one day 1

b. One to 6 days 2

c. Seven days to less than 3 months 3

d. Three months to less than 6 months 4

e. Six months to less than 1 year 5

f. 1 or more years 6

Don't know/Not sure 7

Refused 9

INTERVIEWER GO TO SECTION E (a.18)

22. About how long has it been since you last smoked cigarettes regularly? (67)

a. Less than 1 month 1

b. One month, but less than 3 months 2

c. Three months, but less than 6 months 3

d. Six months, but less than 1 year 4

e. One or more years 5

Don't know/Not sure 7

Refused 9

SECTION E: ALCOHOL CONSUMPTION

These next few questions are about the use of beer, wine, wine coolers, cocktails, or liquor, such as vodka, gin, rum, or whiskey—all kinds of alcoholic beverages that people drink at meals, special occasions, or when just relaxing.

23. Have you had any beer, wine, wine coolers, cocktails, or liquor during the past month, that is, since _____? (68)

a. Yes 1

b. No GO TO SECTION F (a.12) 2

Refused GO TO SECTION F (a.12) 9

24. During the past month, how many days per week or per month did you drink any alcoholic beverages, on the average? (69-71)

a. Days per week . . . . . 1 — —

b. Days per month . . . . . 2 — —

Don't know/Not sure GO TO Q.26 (a.11) 7 7 7

Refused GO TO Q.26 (a.11) 9 9 9

25. A drink is 1 can or bottle of beer, 1 glass of wine, 1 can or bottle of wine cooler, 1 cocktail, or 1 shot of liquor. On the days when you drank, about how many drinks did you drink on the average? (72-73)

a. Number of drinks . . . . . — —

Don't know/Not sure 7 7

Refused 9 9

11

26. Considering all types of alcoholic beverages, that is beer, wine, wine coolers, cocktails, and liquor, as drinks, how many times during the past month did you have 5 or more drinks on an occasion? (74-75)

a. Number of times . . . . . — —

b. None 8 8

Don't know/Not sure 7 7

Refused 9 9

27. And during the past month, how many times have you driven when you've had perhaps too much to drink? (76-77)

a. Number of times . . . . . — —

b. None 8 8

Don't know/Not sure 7 7

Refused 9 9

12

SECTION F: PREVENTIVE HEALTH PRACTICES

Some people visit a doctor for a routine checkup, even though they are feeling well and have not been sick.

28. About how long has it been since you last visited a doctor for a routine checkup?

Was it: *PLEASE READ* (78)

a. Within the past year (0 TO 12 MONTHS AGO) . . . 1

b. Within the past two years (13 TO 24 MONTHS AGO) . . . 2

c. Within the past five years (25 TO 60 MONTHS AGO) OR . . . 3

d. More than five years ago (61+ MONTHS AGO) . . . 4

Don't know/Not sure GO TO Q 30 (a.1) . . . 7

Never, GO TO Q 30 (a.1) . . . 8

Refused GO TO Q 30 (a.1) . . . 9

29. What type of doctor did you see for your last routine check-up?

Was it: *PLEASE READ* (79)

a. Family or General Practitioner . . . 1

b. Internist . . . 2

c. Specialist such as heart, lung, or stomach specialist . . . 3

d. Other . . . 4

(ASK FOR WOMEN ONLY)

e. Obstetrician/Gynecologist . . . 5

Don't know/Not sure . . . 7

Refused . . . 9

13

These next questions are about blood cholesterol, which is a fatty substance found in the blood.

30. Have you ever had your blood cholesterol checked? (80)

a. Yes . . . 1

b. No GO TO Q 32 (a.1) . . . 2

Don't know/Not sure GO TO Q 32 (a.1) . . . 7

Refused GO TO Q 32 (a.1) . . . 9

31. About how long has it been since you last had your blood cholesterol checked?

Was it: *PLEASE READ* (81)

a. Within the past year (0 TO 12 MONTHS AGO) . . . 1

b. Within the past two years (13 TO 24 MONTHS AGO) . . . 2

c. Within the past five years (25 TO 60 MONTHS AGO) OR . . . 3

d. More than five years ago (61+ MONTHS AGO) . . . 4

Don't know/Not sure . . . 7

Refused . . . 9

14

32. Have you ever been told your blood cholesterol level, in numbers? (82)

a. Yes . . . 1

b. No GO TO Q 34 . . . 2

Don't know/Not sure GO TO Q 34 . . . 7

Refused GO TO Q 34 . . . 9

33. What is your blood cholesterol level? (83-85)

Record the number . . . — — —

Don't know/Not sure . . . 7 7 7

Refused . . . 9 9 9

34. Have you ever been told by a doctor or other health professional that your blood cholesterol is high? (86)

a. Yes . . . 1

b. No . . . 2

Don't know/Not sure . . . 7

Refused . . . 9

35. Are you now under the advice of a doctor to reduce your blood cholesterol or blood fat level? (87)

a. Yes . . . 1

b. No GO TO Q 37 (a.1) . . . 2

Don't know/Not sure GO TO Q 37 (a.1) . . . 7

Refused GO TO Q 37 (a.1) . . . 9

15

36. Did the doctor:

36a. —prescribe a medication to lower your blood cholesterol? (88)

- a. Yes . . . 1
- b. No . . . 2
- Don't know/Not sure . . . 7
- Refused . . . 9

36b. —provide you with a low fat or low cholesterol diet? (89)

- a. Yes . . . 1
- b. No . . . 2
- Don't know/Not sure . . . 7
- Refused . . . 9

36c. —refer you to a dietitian, nutritionist, or nurse to help you reduce the fat or cholesterol in your diet? (90)

- a. Yes . . . 1
- b. No . . . 2
- Don't know/Not sure . . . 7
- Refused . . . 9

37. Next, I'd like to ask you about diabetes, sometimes called sugar diabetes. Have you ever been told by a doctor that you have diabetes? (91)

- a. Yes . . . 1
- b. No . . . 2
- Don't know/Not sure . . . 7
- Refused . . . 9

16

SECTION G: DEMOGRAPHICS

These next few questions ask for a little more information about yourself.

38. How old were you on your last birthday? (92-93)

- *Code age in years* . . . — —
- Don't know/Not sure . . . 0 7
- Refused . . . 0 9

39. What is your race? Would you say: *PLEASE READ* (94)

- a. White . . . 1
- b. Black . . . 2
- c. Asian, Pacific Islande: . . . 3
- d. Aleutian, Eskimo, or American Indian . . . 4
- e. Other: *(specify)* _____ . . . 5
- Don't know/Not sure . . . 7
- Refused . . . 9

40. Are you of Hispanic origin such as Mexican American, Latin American, Puerto Rican, or Cuban? (95)

- a. Yes . . . 1
- b. No . . . 2
- Don't know/Not sure . . . 7
- Refused . . . 9

17

41. What is the highest grade or year of school you completed? *READ ONLY IF NECESSARY* (96)

- a. Eighth grade or less . . . 1
- b. Some high school . . . 2
- c. High school grad or GED certificate . . . 3
- d. Some technical school . . . 4
- e. Technical school graduate . . . 5
- f. Some college . . . 6
- g. College graduate . . . 7
- h. Post grad or professional degree . . . 8
- Refused . . . 9

42. Are you currently: *PLEASE READ* (97)

- a. Employed for wages . . . 1
- b. Self employed . . . 2
- c. Out of work for more than 1 year . . . 3
- d. Out of work for less than 1 year . . . 4
- e. Homemaker . . . 5
- f. Student . . . 6
- OR
- g. Retired . . . 7
- Refused . . . 9

18

43. And are you: *PLEASE READ* (98)

- a. Married . . . 1
- b. Divorced . . . 2
- c. Widowed . . . 3
- d. Separated . . . 4
- e. Never been married . . . 5
- OR
- f. A member of an unmarried couple . . . 6
- Refused . . . 9

44. Which of the following categories best describes your annual household income from all sources? *PLEASE READ* (99)

- a. Less than $10,000 . . . 1
- b. $10 to $15,000 . . . 2
- c. $15 to $20,000 . . . 3
- e. $20 to $25,000 . . . 4
- e. $25 to $35,000 . . . 5
- f. $35 to $50,000 . . . 6
- OR
- g. Over $50,000 . . . 8
- Don't know/Not sure . . . 7
- Refused . . . 9

19

45. About how much do you weigh without shoes? (100-102)

a. Weight . . . . . ___ ___ Pounds

Don't know/Not sure 7 7 7

Refused 9 9 9

46. About how tall are you without shoes? (103-105)

a. Height . . . . . ___/___ Ft Inches

Don't know/Not sure 7 7 7

Refused 9 9 9

47. INTERVIEWER: INDICATE SEX OF RESPONDENT. ASK IF NECESSARY (106)

a. Male, GO TO SECTION I (p.24) 1

b. Female 2

SECTION H: WOMEN'S HEALTH

20

These next questions are about mammograms, which are x-ray tests of the breast to look for cancer.

48. Have you ever had a mammogram? (107)

a. Yes 1

b. No GO TO Q 50b (bottom of p.21) 2

Don't know/Not sure GO TO Q 51 (p.22) 7

Refused GO TO Q 51 (p.22) 9

49. About how long has it been since you had your last mammogram?

Was it: PLEASE READ (108)

a. Within the past year GO TO Q 51 (p.21) (0 TO 12 MONTHS AGO) . . . 1

b. Within the past two years (13 TO 24 MONTHS AGO) . . . 2

c. Within the past five years (25 TO 60 MONTHS AGO) OR . . . 3

d. More than five years ago (61+ MONTHS AGO) . . . 4

Don't know/Not sure 7

Refused 9

50a. What is the **most important reason** that you did not have a mammogram in the last year?

DO NOT READ LIST. RECORD ONLY ONE ANSWER (109)

a. Not recommended by doctor / Doctor never said it was needed . . . 1

b. Not needed / Not necessary . . . 2

c. Never heard of mammogram . . . 3

d. Cost . . . 4

e. No insurance to pay for it . . . 5

f. Other . . . 6

Don't know/Not sure . . . 7

Refused . . . 9

21

51. Was your last mammogram done as part of a routine checkup, because of a breast problem, or because you've already had breast cancer? (110)

a. Routine checkup 1

b. Breast problem 2

c. Had breast cancer 3

Don't know/Not sure 7

Refused 9

52. Whose idea was it for you to have this last mammogram - was it your idea, your doctor's idea, or someone else's idea?

PROBE FOR THE MOST INFLUENTIAL. RECORD ONLY ONE RESPONSE. (111)

a. Respondent's idea 1

b. Doctor's idea 2

c. Someone else's idea 3

Don't know/Not sure 7

Refused 9

INTERVIEWER: GO TO Q 53, PAGE 23

50b. What is the **most important reason** that you never had a mammogram?

DO NOT READ LIST. RECORD ONLY ONE ANSWER (109)

a. Not recommended by doctor / doctor never said it was needed . . . 1

b. Not needed / not necessary . . . 2

c. Never heard of mammogram . . . 3

d. Cost . . . 4

e. No insurance to pay for it . . . 5

f. Other . . . 6

Don't know/Not sure . . . 7

Refused . . . 9

22

The next questions are about breast physical examination, which is when the breast is felt for lumps by a doctor or medical assistant.

53. Have you ever had a breast physical exam by a doctor or a medical assistant? (112)

a. Yes 1

b. No GO TO Q 55 (p.23) 2

Don't know/Not sure GO TO Q 55 (p.23) 7

Refused GO TO Q 55 (p.23) 9

54. About how long has it been since your last breast physical exam? (113)

Was it:

a. Within the past year (0 to 12 months ago) . . . 1

b. Within the past two years (13 to 24 months ago) . . . 2

c. Within the past five years (25 to 60 months ago) . . . 3

d. More than five years ago (61+ months) . . . 4

Don't know/Not sure . . . 7

Refused . . . 9

55. Was your last breast physical exam done as part of a routine checkup, because of a breast problem, or because you've already had breast cancer? (114)

a. Routine checkup 1

b. Breast problem 2

c. Had breast cancer 3

Don't know/Not sure 7

Refused 9

23

INTERVIEWER: ASK THESE TWO QUESTIONS ONLY OF FEMALES BETWEEN 18 AND 44 YEARS OF AGE.
OTHERWISE, GO TO SECTION I (p.24).

56. To your knowledge, are you now pregnant? (115)

a. Yes 1

b. No *GO TO SECTION I (p.24)* 2

Don't know/Not sure *GO TO SECTION I (p.24)* . . . 7

Refused *GO TO SECTION I (p.24)* 9

57. During what month is your baby due? (116-117)

Code Months
Jan 01
Feb 02
Mar 03
Apr 04
May 05
Jun 06
Jul 07
Aug 08
Sep 09
Oct 10
Nov 11
Dec 12

Code month . . . . . — —

Don't know/Not sure 7 7

Refused 9 9

24

SECTION I: AIDS

These next few questions are to determine your beliefs and opinions about the national health problem of AIDS.

58. Have you ever heard the AIDS virus called HIV? (118)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

59. To your knowledge, are there drugs available which can lengthen the life of a person infected with the AIDS virus? (119)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

60. Do you think a person who is infected with the AIDS virus can look and feel well and healthy? (120)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

61. There has been a lot of talk about how you can and cannot get infected with the AIDS virus. Do you think you can get infected from:

	Yes	No	DK/NS	Ref	
a. Giving blood	1	2	7	9	(121)
b. Mosquitoes or other insects	1	2	7	9	(122)

25

62. Do you have a child or children in kindergarten through eighth grade? (123)

a. Yes 1

b. No *GO TO Q 65* 2

Don't know/Not sure *GO TO Q 65* 7

Refused *GO TO Q 65* 9

63. Would you allow your child to be in the same classroom with a child who is infected with the AIDS virus? (124)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

64. At what grade do you think your child should begin AIDS education in school? (125-126)

Code grade . . . . . — —

Never 8 8

Don't know/Not sure 7 7

Refused 9 9

65. Would you eat in a restaurant where the cook is infected with the AIDS virus? (127)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

26

66. Would you be willing to work with a person who is infected with the AIDS virus? (128)

a. Yes 1

b. No 2

Don't know/Not sure 7

Refused 9

67. Where could you go to be tested for the AIDS virus infection? (129-130)
PROBE FOR OTHER PLACES IF ONLY ONE RESPONSE IS GIVEN

a. *Facility code* . . . . . — —

(131-132)

b. Where else could you go? . . . . . — —

PLEASE DO NOT READ LIST

a. Private doctor, HMO 01

b. Blood bank, plasma center, Red Cross 02

c. Health department 03

d. AIDS clinic, AIDS testing site 04

e. Hospital, emergency room 05

f. Family planning clinic 06

g. STD clinic 07

h. Community health clinic, primary care clinic . . 08

i. Company or industry clinic 09

j. Military induction or examination 10

k. Other 87

l. No place 88

Don't know/Not sure 77

Refused 99

27

68. Some people use condoms to keep from getting the AIDS virus through sexual activity. How effective do you think using a condom is in preventing getting the AIDS virus through sexual activity?

Would you say: *PLEASE READ* (133)

a. Very effective 1

b. Somewhat effective 2
OR

c. Not at all effective 3

DO NOT READ THESE RESPONSES

Don't know how effective 4

Don't know method 5

Refused 9

69. How many telephone numbers will reach this household, including the number I used today?

DIFFERENTIATE BETWEEN TELEPHONE NUMBERS AND TELEPHONE SETS IF NECESSARY. INCLUDE ALL TELEPHONE NUMBERS THAT CAN REACH HOUSEHOLD (134)

a. Total telephone numbers . . . . . ___

CLOSING STATEMENT

That's my last question. Let me emphasize that your answers cannot be identified with your name. Everyone's answers will be combined to give us information about the health practices of people in this state. Thank you very much for your time and cooperation.

28

MODULE 1: COUNTY OF RESIDENCE:

1. What county do you live in? (135-137)

a. County Code . . . . . ___

Don't know/Not sure 7 7 7

Refused 9 9 9

State added questions:

1. How many members of your household are under 18 years old?
Members under 18 (0-20)
Don't know/not sure
Refused

2. Do you have a working smoke detector in your home?
yes
no
Don't know/not sure
Refused

3. If yes, have you tested your smoke detector within the past month to see if it works?
Yes
No
Can't remember/don't know

APPENDIX B

1990
Prevalence of Health Risks in Texas
As Compared to 46 Other States

Health Risk	Texas Percent	U.S. Median Percent
Acute Drinking	19	15
Chronic Drinking	6	3
Drinking and Driving	5	3
Cholesterol Check	59	62
Cigarette Smoking	26	23
Hypertension	16	16
Mammogram	56	58
Overweight	22	23
Seatbelt Non-Use	7	14
Sedentary Lifestyle	53	58

Appendix C
Selected Texas Year 2000 Health Objective Data: 1987-1990[1]

Statewide percentages of rates Topic	Indicator	1987	1988	1989	1990	Texas Year 2000 Objectives
Maternal and Child Care	Maternal mortality per 100,00 live births (ICD 630-676)	8.6	7.9	9.4	5.7	4.0
	Women receiving an adequate number of prenatal visits as defined by the Kessner Index (percent of live births)	59%	58%[2]	59%	61%	65%
	Infant mortality per 1,000 live births	9.1	9.0	9.1	8.0	7.0
	Low birth weight infants (percent of live births)	6.9%	6.8%	7.0%	6.9%	6.0%
Tobacco	Prevalence of smoking during pregnancy (1988 data based on BRFS, 1989-1990 data based on live births)	NA	18%	11.9%	10.5%	10%
	Reduce prevalence of tobacco use by youth and adults (BRFS data)	23%	24%	22%	23%	15%
Violent and Abusive Behavior	Number of Suicides (ICD E950-E959)	2,180	2,255	2,073	2,269	<1500
Unintentional Injuries	Deaths caused by motor vehicles per 100,000 population (ICD E810-E825)	19.6	20.0	19.9	19.5	17.3
	Deaths caused by Falls per 100,000 population (ICD E880-E888)	3.5	3.5	3.8	3.8	3.3
	Deaths caused by Poisoning per 100,000 population (ICD E850-E869)	2.1	2.3	2.2	2.1	2.2

	Deaths caused by Residential Fires per 100,000 population (ICD E890)	1.47	1.34	1.41	1.25	1.17
Heart Disease and Stroke	Deaths due to heart disease (total age-adjusted rate per 100,000 population, adjusted to 1980 U.S. pop.) (ICD 390-398, 402, 404-429	262	262	254	253	190
	** Special target population: Blacks[3]	329	334	335	334	234
	Deaths due to stroke (cerebrovascular disease) total age-adjusted rate per 100,000, adjusted to 1980 U.S. population) (ICD 430-438)	53	52	52	53	25
	** Special target population: Blacks	75	77	80	80	38
Physical Activity and Fitness	Texans 18 and older who participate in at least moderate physical activities 3+ days/wk for 20 minutes+/occasion (BRFS data)	36%	32%	38%	38%	55%

1. All data are from vital statistics records unless otherwise noted.
2. Percentage or rate is slightly different from Texas Year 2000 Objectives published data because of differences in calculation methods.
3. Rates and projections differ from year 2000 published rates because of a previous calculation error.

Source: Texas Vital Statistics,1990

Appendix D
YEARS OF POTENTIAL LIFE LOST - 1990
LEADING CAUSES OF PREMATURE DEATH
TOTAL POPULATION

CAUSE	TOTAL		WHITE		HISPANIC		BLACK	
	YPLL	RATE*	YPLL	RATE*	YPLL	RATE*	YPLL	RATE*
Accidents	161,373.0	10.57	92,286.0	9.88	45,248	11.13	23,838.5	12.78
Malignant Neoplasms	113,588.5	7.44	75,407.5	8.07	20,026.0	4.93	18,155.0	9.74
Heart Disease	87,496.0	5.73	53,582.5	5.74	13,907.0	3.42	20,006.5	10.73
Homicide	77,145.0	5.05	19,815.5	2.12	25,116.5	6.18	32,213.0	17.28
Certain Conditions in Perinatal Period	67,358.5	4.41	25,000.0	2.68	21,796.0	5.36	20,562.5	11.03
Congenital Anomalies	53,602.0	3.51	26,944.0	2.88	18,708.0	4.60	7,950.0	4.26
Human Immunodeficiency Virus Infection	50,414.0	3.30	32,737.5	3.51	8,696.5	2.14	8,980.0	4.82
Suicide	49,594.5	3.25	35,451.5	3.80	9,529.5	2.34	4,613.5	2.47
Cerebrovascular Diseases	16,737.0	1.10	8,238.5	0.88	4,372.0	1.08	4,126.5	2.21
Chronic Liver Disease and Cirrhosis	13,323.5	0.87	6,746.5	0.72	4,761.0	1.17	1,816.0	0.97
Pneumonia and Influenza	13,083.0	0.86	5,497.5	0.59	3,950.0	0.97	3,635.5	1.95
Diabetes Mellius	10,132.0	0.66	5,527.5	0.59	2,553.5	0.63	2,051.0	1.10
Chronic Obstructive Pulmonary Diseases	6,848.5	0.45	4,753.5	0.51	711.0	0.17	1,384.0	0.74
ALL OTHER	129,671.0	8.49	65,366.5	7.00	33,384.0	8.21	30,920.5	16.58

* Rates per 1,000 propulation, ages 0-64.